



FLEXIBLE SPENDING ACCOUNT
ORTHODONTIC SERVICES RECEIPT

Attach to the Payment Request form

Employee Information

Employer: _____

Employee Name: _____ Date _____

Patient Name: _____ Phone: _____

Service Provider Information

Dentist Name: _____ Phone: _____

Address: _____

Treatment Information

Start Date: _____ / _____ / _____ Total Fee: \$ _____

Initial Fee: \$ _____ for _____ Months

Monthly Fee: \$ _____ for _____ Months

Initial Fee is for services rendered from: _____ / _____ / _____ to _____ / _____ / _____

First Monthly fee is due: _____ / _____ / _____

Are any of the above charges covered by any other insurance company? Yes No

If "Yes", please attach your Explanation of Benefits (EOB) form or a Predetermination form.

Completed by: _____ Date: _____

Dental Office